# Elsdon Enterprises Limited - Ashlea Grove

## Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Elsdon Enterprises Limited

**Premises audited:** Ashlea Grove Rest Home

**Services audited:** Rest home care (excluding dementia care); Dementia care

**Dates of audit:** Start date: 3 August 2015 End date: 4 August 2015

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 24

# Executive summary of the audit

## Introduction

This section contains a summary of the auditors’ findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

* consumer rights
* organisational management
* continuum of service delivery (the provision of services)
* safe and appropriate environment
* restraint minimisation and safe practice
* infection prevention and control.

As well as auditors’ written summary, indicators are included that highlight the provider’s attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

**Key to the indicators**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

Ashlea Grove is one of four aged care facilities which are privately owned and operated by Elsdon Enterprises Ltd. The service is certified to provide rest home and dementia level care for up to 35 residents. Ashlea Grove is managed by two owner/directors who share the managers’ role and have been at Ashlea Grove for the past four months. Two part time registered nurses have been employed and have also been in their respective roles for the past four months. Family and residents interviewed spoke positively about the care and support provided and the improvements that the new management team have made. These include renewal of floor coverings and new furniture in the rest home and increased activities hours to cover Monday to Sunday.

This certification audit was conducted against the health and disability sector standards and the district health board contract. The audit process included the review of policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, staff and management.

Improvements are required in relation to policies and procedures to include the use of the InterRAI assessment tool, documentation of clinical care for residents following incidents, InterRAI training for the registered nurses, completing the annual education programme, staff entries in resident files to include full name and designation, aspects of assessments, care planning and interventions, medication documentation, registered nurse competencies, secure storage of chemicals, floor coverings in the dementia unit, review of the infection control programme and infection control training for the registered nurse.

## Consumer rights

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Standards applicable to this service fully attained. |

The staff at Ashlea Grove strive to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner’s Code of Consumers’ Rights. Information about the code of rights and services is easily accessible to residents and families. Policies are implemented to support residents’ rights. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Staff interviewed were familiar with processes to ensure informed consent. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and a complaints register is maintained.

## Organisational management

|  |  |  |
| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

The quality and risk management programme includes service philosophy, goals and a quality planner. Quality activities are conducted and this generates improvements in practice and service delivery. Residents meetings have been held and residents and families have been surveyed. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported. Discussions with families identified that they are fully informed of changes in health status. Staff files are maintained and annual appraisals have been conducted. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support.

## Continuum of service delivery

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

There is information available for residents and relatives prior to entry to the service. Residents are assessed prior to entry to the service. Care plans are individually developed with the resident, and family/whānau involvement is included where appropriate. Care plans are evaluated six monthly or more frequently when clinically indicated. Residents and family interviewed confirmed that the care plans are consistent with meeting residents' needs. Risk assessment tools and monitoring forms are available to assess effectively, the level of risk and support required for residents. Activities are provided that are meaningful and ensure that the resident maintains involvement in the community. A medication management system is implemented. All caregivers who administer medications have completed annual competencies for medication administration. There are three monthly GP medication reviews. The menu is designed by a dietitian with summer and winter menus. Dietary requirements are provided where special needs are identified.

## Safe and appropriate environment

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| --- | --- | --- |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Some standards applicable to this service partially attained and of low risk. |

Ashlea Grove has a current building warrant of fitness. Reactive and preventative maintenance is carried out. Medical equipment and electrical appliances have had electrical checks. There is a designated laundry which includes the safe storage of cleaning and laundry chemicals. Residents’ rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. There are sufficient communal areas within the rest home and dementia areas, which include lounge and dining areas, and smaller seating areas. The service has implemented policies and procedures for civil defence and other emergencies and six monthly fire drills are conducted. There is a civil defence kit and evidence of supplies in the event of an emergency in line with Civil Defence guidelines. External garden areas are available with suitable pathways, seating and shade provided.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

Ashlea Grove has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit there were no residents with restraint and one enabler.

## Infection prevention and control

|  |  |  |
| --- | --- | --- |
| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | Some standards applicable to this service partially attained and of low risk. |

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and also as part of the on-going in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 33 | 0 | 8 | 4 | 0 | 0 |
| **Criteria** | 0 | 80 | 0 | 9 | 4 | 0 | 0 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Unattained Negligible Risk**  **(UA Negligible)** | **Unattained Low Risk**  **(UA Low)** | **Unattained Moderate Risk**  **(UA Moderate)** | **Unattained High Risk**  **(UA High)** | **Unattained Critical Risk**  **(UA Critical)** |
| **Standards** | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 |

# Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers’ Rights (the Code) policy and procedure is implemented. Discussions with staff (three caregivers, two activities coordinator, two registered nurses, and two managers) confirm their familiarity with the Code. Interviews with five rest home residents and four relatives (three dementia and one rest home) confirm the services being provided are in line with the Code of rights. Code of rights and advocacy training is required to be provided for staff (link #1.2.7.5). |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Informed consent and resuscitation orders were appropriately recorded as evidenced in six of six resident files (three rest home and three dementia) reviewed. Advised by staff that family involvement occurs with the consent of the resident. Residents interviewed confirmed that information was provided to enable informed choices and that they were able to decline or withdraw their consent. Six sighted resident admission agreements were signed. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | An advocacy policy and procedure includes how staff can assist residents and families to access advocacy services. Contact numbers for advocacy services are included in the policy, in the resident information folder and in advocacy pamphlets that are available at reception. Residents’ meetings include discussing previous meeting minutes and actions taken (if any) before addressing new items. Discussions with relatives identify that the service provides opportunities for the family/EPOA to be involved in decisions. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Interviews with residents and relatives confirm that visiting can occur at any time. Family members were seen visiting on the days of the audit. Key people involved in the resident’s life are documented in the care plans. Discussions with residents and relatives verify that they are supported and encouraged to remain involved in the community. Ashlea Grove staff support on-going access to community. Entertainers are invited to perform at the facility. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | A complaints policy and procedure is in place. Residents/family can lodge formal or informal complaints through verbal and written communication, resident meetings, and complaint forms. Information on the complaint’s forms includes the contact details for the Health and Disability Advocacy Service. Complaints forms are available at reception. A review of the complaints log/register evidences that the appropriate actions have been taken in the management and processing of complaints. A complaints procedure is provided to residents within the information pack at entry. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | The service provides information to residents that include the Code of rights, complaints and advocacy information. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Interviews with residents and relatives identify they are well informed about the code of rights. The managers and registered nurses provide an open-door policy for concerns or complaints. Resident meetings have been held, providing the opportunity to raise concerns in a group setting. An annual resident satisfaction survey has been conducted. The survey includes questions relating to complaints process and residents rights, with respondents reporting they were overall satisfied or very satisfied.  Advocacy pamphlets, which include contact details, are included in the information pack and are available at reception. The service has an advocacy policy that includes a definition of advocacy services, objectives and process/procedure/guidelines. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The service has policies, which align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were able to describe the procedures for maintaining confidentiality of resident records. The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. Church services are held weekly. Contact details of spiritual/religious advisors are available to staff. Residents and relatives interviewed confirm the service is respectful and that they are given the right to make choices. Six care plans reviewed identify specific individual likes and dislikes. Staff education and training on abuse and neglect has been provided. Communal toilets in the dementia unit have been renovated to ensure privacy is maintained. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | There is a Māori heath plan and an individual’s values and beliefs policy which includes cultural safety and awareness. Discussions with staff confirm their understanding of the different cultural needs of residents and their whānau.  There are no residents at Ashlea Grove who identify as Māori. There is information and websites provided within the Māori health plan to provide quick reference and links with local Māori. Interviews with staff confirm they are aware of the need to respond appropriately to maintain cultural safety. Policies include guidelines about the importance of whānau. Cultural awareness training has been provided. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | Care planning includes consideration of spiritual, psychological and social needs. Residents interviewed indicate that they are asked to identify any spiritual, religious and/or cultural beliefs. Relatives report that they feel they are consulted and kept informed. Family involvement is encouraged e.g. invitations to residents meetings and facility functions. Care plans reviewed include the residents’ social, spiritual, cultural and recreational needs. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The staff employment process includes the signing of house rules and an Ashlea Grove code of conduct. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on dignity and privacy and boundaries, evidenced in interview with staff and management. Interviews with staff confirm their understanding of professional boundaries. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The quality programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment, and the requirement to attend orientation and on-going in-service training. The recent resident satisfaction survey reflects high levels of satisfaction with the services that are received. Policies and procedures have been updated by the organisational senior management team and are available to staff. Staff meetings and residents meetings have been conducted.  Residents and relatives interviewed spoke very positively about the care and support provided. Staff had a sound understanding of principles of aged care and state that they feel supported by the new managers and new registered nurses. There are implemented competencies for caregivers (link finding #1.3.12.3). There are clear ethical and professional standards and boundaries within job descriptions. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Policies are in place relating to open disclosure. Residents interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. A sample of incident reports reviewed for June and July 2015, and associated resident files, evidenced recording of family notification. Relatives interviewed confirm they are notified of any changes in their family member’s health status. The managers and registered nurses can identify the processes that are in place to support family being kept informed. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. Residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement.  The facility has an interpreter policy to guide staff in accessing interpreter services. Residents (and their family/whānau) are provided with this information at the point of entry. Families are encouraged to visit. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Elsdon Enterprises (Ltd) are the proprietors of Ashlea Grove rest home in Milton. The organisation has three other facilities. The service can provide care for up to 35 residents – 20 rest home and 15 dementia. The breakdown of residents is 24 residents in total – 8 rest home plus one rest home respite (of possible 20), and 15 dementia level residents. One dementia level resident is under the age of 65.  A manager from another home was present on the days of audit and advised that she has been providing the new managers with support and guidance in their new management role. The organisation is actively working towards having a more cohesive and unified approach with the sharing of information and support amongst the four facilities. Policies and procedures have been reviewed at head office. The new managers have had four weeks of training at head office prior to commencement of their management role at Ashlea Grove. One manager is also a company director. The two managers are supported by the manager from another home and the two part time registered nurses. One registered nurse is experienced in aged care, and one is experienced in primary care. Both have a current annual practicing certificate. The managers’ report to the governing board on a monthly basis on a variety of topics relating to quality and risk management. The service has a current strategic and business plan, which includes a current quality assurance and risk management plan. A quality management system is implemented which includes gathering data and information to provide opportunities for quality improvement. The organisation has a philosophy of care, which includes a mission statement. The new managers have been focused on improving the physical environment for residents and staff and on improving the culture and atmosphere of the home. Residents, families and staff confirm that improvements have been noted. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | In the absence of either one of the managers, the other assumes the role. If both are absent, then a registered nurse is in charge with support from senior care staff and head office. A review of the documentation, policies and procedures and from discussions with staff identifies the service's operational management strategies, and quality and risk programme are in place to minimise the risk of unwanted events and enhance quality. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | The business plan, quality assurance, and risk management planning procedures describe Ashlea Grove’s quality improvement processes. The risk management plan describes objectives, management controls and assigned responsibility. Progress with the quality and risk management programme is monitored by the management team and discussed at management meetings and staff meetings. Monthly reviews have been completed for all areas of service. Meeting minutes are maintained and staff are expected to read the minutes and sign off when read. Minutes for all meetings include actions to achieve compliance where relevant. Discussions with the registered nurses and caregivers confirm their involvement in the quality programme. Resident/relative meetings are held. Restraint and enabler use is reported within the management meetings.  Data is collected on complaints, accidents, incidents, infection control and restraint use. There is an internal audit schedule, and the managers have been working towards ensuring that all aspects of the calendar have been completed and are up to date. Areas of non-compliance identified through quality activities are actioned for improvement. The service has a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. The service has policies/procedures to support service delivery with the exception of InterRAI assessment policy. There is a document control policy that outlines the system implemented whereby all policies and procedures are reviewed regularly. New policies reviewed and introduced from head office have been forwarded to staff and discussed at staff meetings. Death/Tangihanga policy and procedure that outlines immediate action to be taken upon a consumer’s death and that all necessary certifications and documentation is completed in a timely manner. Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention. Residents are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | PA Moderate | There is an accidents and incidents reporting policy. Advised that accidents and near misses are investigated by a registered nurse and a manager and analysis of incident trends occurs. There is a discussion of incidents/accidents at staff meetings including actions to minimise recurrence. A review was conducted of incident and accident forms for June (26) and July (25) 2015. A sample of six corresponding resident files were reviewed. Advised that a registered nurse conducts clinical follow up of residents, however, documentation reviewed did not support this.  Discussions with the manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. A pressure area for one resident was not reported via the incident reporting system. Family notification was recorded on incident forms and in progress notes reviewed. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low | There are human resource management policies in place, which includes a recruitment and staff selection process. Policies require that relevant checks are completed to validate the individual’s qualifications, experience and veracity. A copy of practising certificates including the registered nurse and general practitioners is kept. Six staff files were reviewed and included two registered nurses, three caregivers and one activities coordinator. Staff files evidence that reference checks were completed before employment was offered.  The service has in place an orientation programme that provides new staff with relevant information for safe work practice. The new managers and registered nurses have been providing the in-service education programme since April 2015. Some areas are still to be completed, but the majority is scheduled. Caregivers have completed an aged care education programme. An external assessor attends the facility to provide that training and assesses staff in completing the unit standards. The managers and registered nurses are able to attend external training. The organisation is intending to hold a managers conference in November 2015. Annual staff appraisals were evident in files reviewed for staff who had been employed for longer than one year. There are 16 caregivers who work in the dementia unit – 11 have completed the required dementia unit standards and five are in the process of completing. These five staff have been employed in the last 12 months. One registered nurse is in the process of completing the InterRAI training and one registered nurse has not yet started the training. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The good employer policy includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the rest home and dementia residents. At least one staff member is rostered on in each area at any one time with one staff on-call. The managers and registered nurses share on call after hours and weekends. Advised that extra staff can be called on for increased resident requirements. Interviews with three caregivers, residents and family members identify that staffing is adequate to meet the needs of residents. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | PA Low | The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. Residents' files are protected from unauthorised access by being locked away in the nurses’ stations. Informed consent to display photographs is obtained from residents/family/whānau on admission. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Entries in records are initialled by the caregiver or registered nurse making the entry and not fully signed. Individual resident files demonstrate service integration. This includes medical care interventions and records of the activities coordinator. Medication charts are in a separate folder. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | Residents are assessed prior to entry to the service by the needs assessment team, and an initial assessment was completed on admission in files sampled. The service has an information pack available for residents/families/whānau at entry and it includes associated information such as the Code, advocacy, informed consent, and the complaints procedure. The six files reviewed included the admission agreement, which aligns with the ARC contract and exclusions from the service are included in the admission agreement. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | The transfer/discharge/exit procedures include a transfer/discharge form and the completed form is placed on file. The registered nurses interviewed stated that a staff member escorts the resident if no family were available to assist with transfer, and copies of documentation are forwarded with the resident. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | The service uses an individualised medication system which are checked in on delivery. Medications are managed appropriately in line with required guidelines and legislation, with the exception of the weekly checks of the controlled drug register. The service has in place policies and procedures for ensuring all medicine related recording and documentation is: a) legible, b) signed and dated, and c) meets acceptable good practice standards. Medication charts sampled were reviewed three monthly by the attending GP. Resident photos and documented allergies or nil known were evident on all medication charts reviewed. An annual medication administration competency was completed for all caregivers who administer medications and medication training has been conducted, except for the registered nurses who have not completed annual training or competencies. There was evidence of transcribing occurring on administration signing sheets.  There is a self-medicating resident’s policy and procedures in place. There were currently no residents self-medicating. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | There is a small functional kitchen at Ashlea Grove. All food is cooked on site. The service provides meals on wheels to the community and the local district council has completed a safety check and issued compliance certificate in March 2015. The service employs a cook who is supported by a weekend cook and care staff. Both cooks have completed safe food handling training. A cleaning schedule is maintained. Fridge and freezer temperatures are recorded and items are dated. The service has a four week winter and summer menu reviewed by a dietitian. Resident files reviewed show evidence of dietary profile documented on admission and sent through to the kitchen. This is updated as residents needs change, as evidence in the folder of profiles reviewed. Special or modified diets are catered for. Soft and puree dietary needs are documented in files sampled. This includes consideration of any particular dietary needs (including cultural needs). Meal service was observed in both dementia unit and rest home area. Hot food meals are placed in preheated serving dishes and transported to each dining room. There is evidence that there is additional nutritious snacks available over 24 hours and this was confirmed by care staff. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | The service has a process for declining entry should that occur. This includes informing persons and referrers (as applicable) the reasons why the service has been declined. The reason for declining service entry to residents is recorded and communicated to the resident/family/whānau. The reason for declining would be if the client did not meet the level of care provided at the facility or there are no beds available. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | PA Low | All residents were admitted with a care needs level assessment completed by the needs assessment and service coordination team, prior to admission for files sampled. Personal needs information was gathered during admission, which formed the basis of resident goals and objectives in files sampled. Assessments were reviewed at least six monthly for resident files sampled. Assessments have not always been completed for resident’s needs. One of the service’s registered nurses is completing the InterRAI assessor training; currently there has been no evaluations due to evidence the usage of InterRAI assessments at Ashlea Grove. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate | The initial care plan is to be developed from the initial assessment; however, initial care plans were not evident in all the resident files reviewed. The long term care plan recorded the resident’s problem/need, objectives and interventions for identified issues in files reviewed. Short term care plans have not been utilised for all acute health needs. Resident files reviewed identified that family were involved in the care plan development and on-going care needs of the resident.  Three dementia resident files reviewed identified current abilities, level of independence, identified needs and specific behavioural management strategies. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate | Care plans reviewed were current with interventions updated.  Continence products are available and resident files include a urinary continence assessment (linkage # 1.3.4 2). Specialist continence advice is available as needed and this could be described.  Monthly weighs have been completed in files sampled, however there were gaps in documentation. Referral to dietitian occurs as required as confirmed by registered nurses interviewed.  Dressing supplies are available and all treatment rooms are stocked for use. There are currently two residents in the dementia unit with wounds. These wounds include chronic diabetic leg ulcers and a sacral pressure area and one resident with reoccurring cellulitis of both legs, which the service is monitoring. Wound assessments and management plans are completed for two of the three wounds and there was evidence of referral to the general practitioner. Progress notes refer to the sacral pressure area cares provided. The resident was nursed on an air mattress and was receiving regular turns. The pressure injury was not reported via the incident reporting procedures (link #1.2.4.3). Wound management documentation does not include frequency required for dressing changes.  Short term care plans are available for use for changes in health status with exceptions (link finding #1.3.5.2). |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The activity programme is planned monthly. Activities planned for the day are displayed on notice boards around the rest home and dementia areas. An activity plan is developed for each individual resident based on assessed needs of the functional activity assessment completed on admission. Activity plans were reviewed six monthly in files sampled. Activity progress notes are maintained. Residents are encouraged to join in activities that are appropriate and meaningful and are encouraged to participate in community activities. Community groups are invited to participate in the programme. The service has a van that is used for resident outings. Resident meetings provide a forum for feedback relating to activities. Residents and family members interviewed discussed enjoyment in the programme and the diversity offered to all residents. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Care plan reviews are signed as completed six monthly by an RN and were updated as changes were noted in care requirements in files sampled. Care plan evaluations stated the degree of achievement of goals and interventions in all files sampled.  GPs review residents three monthly or when requested if issues arise or health status changes. General practitioner interviewed stated that the communication from the service is appropriate and in a timely fashion. The service carries out the GP’s instructions (link #1.3.6.1), giving her confidence in the management of the residents. It was noted on interview that the GP has requested that the service improve the quality of information passed on when a GP is called for review of residents. In response, the service has scheduled training for care staff around taking observations and conducting neurological observations (link #1.2.7.5). |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | The service facilitates access to other medical and non-medical services e.g. diabetic services, rheumatology clinic, physiotherapist and mental health services for older people. Referrals to specialists are made by the GP. Referral forms and documentation are maintained on resident files as sighted. Residents' and/or their family/whānau interviewed reported they are involved as appropriate when referral to another service occurs. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | PA Low | Chemicals are labelled with manufacturer labels with the exception of two chemicals, one of which was decanted. There are designated areas for storage of cleaning/laundry chemicals and chemicals were stored. On day of audit cleaner’s cupboard was seen to be unlocked. Laundry and sluice rooms are locked when not in use. Safety data charts were available for all chemicals in use. Gloves, aprons, and face visors are available for staff. Safe chemical handling training has been provided. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Low | The service displays a current building warrant of fitness, which expires on 12 July 2016. Hot water temperatures are checked monthly. Medical equipment and electrical appliances have been tested, tagged, and calibrated, with the exception of the chair scales. Scales were calibrated on day of audit. Regular and reactive maintenance occurs. Residents were observed to mobilise safely within the facility. There are sufficient seating areas throughout the facility. The exterior has been well maintained with ramps, safe paving, outdoor shaded seating, lawn and gardens. The dementia area has a secure garden area. Caregivers interviewed confirmed there was adequate equipment to carry out the cares according to the resident needs as identified in the care plans. Floor coverings have been replaced in the rest home communal bathrooms and the hallway.  The service has a van for transporting residents, which has a current registration and warrant of fitness. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | All resident rooms in Ashlea Grove are single rooms. There are sufficient numbers of resident communal toilets in close proximity to resident rooms and communal areas. Visitor toilet facilities are available. Residents interviewed stated their privacy and dignity is maintained while attending to their personal cares and hygiene. The communal toilets are well signed and identifiable and include vacant/in-use signs. Communal bathrooms in the dementia unit have been modified and now have doors on each toilet and are screened to ensure privacy for residents. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | The resident rooms are of sufficient size to meet the resident’s assessed needs. Residents are able to manoeuvre mobility aids around the bed and personal space. All beds are of an appropriate height for the residents. Caregivers interviewed reported that rooms have sufficient area to allow cares to take place. The bedrooms were observed to be personalised. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There is a large lounge and dining room, and two smaller lounges available in dementia area and dining room and lounge in rest home. The lounge area in rest home has recently been redecorated and new lounge furniture has been provided. All areas are easily accessible for the residents. Residents interviewed reported they are able to move around the facility and staff assisted them when required. Activities take place in any of the lounges. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | The service has documented systems for monitoring the effectiveness and compliance with the service policies and procedures. There is a separate laundry area where all linen and personal clothing is laundered by the care staff. Staff attend infection control education and there is appropriate protective clothing available. Care staff complete cleaning/laundry tasks. Manufacturer’s data safety charts are available. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | A New Zealand Fire Service approved fire evacuation plan is in place. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking. Short-term backup power for emergency lighting is in place.  Visitors and contractors sign in at reception when visiting. Fire drills have been conducted six monthly. There is a staff member with a first aid certificate on each shift. Security checks are conducted each night by staff. There are call bells in the residents’ rooms, and lounge/dining room areas. Residents’ rooms were observed to have their call bells in close proximity. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All communal and resident bedrooms have external windows with plenty of natural sunlight. General living areas and resident rooms are appropriately heated and ventilated. Residents and family interviewed stated the environment was warm and comfortable. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | PA Low | Ashlea Grove rest home has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. A registered nurse is the designated infection control nurse with support from the managers and staff (infection control team). Minutes are available for staff. Audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme was last reviewed in June 2014. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | A registered nurse at Ashlea Grove is the infection control nurse. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team (comprising the management team and care staff) has good external support from the local laboratory infection control team and IC nurse specialist at the DHB. The infection control team is representative of the facility. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | There is infection control policies and procedures appropriate to for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies were originally developed by an external provider and have been reviewed and updated annually by another group manager and the group’s clinical leader. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | PA Low | The infection control policy states that the facility is committed to the on-going education of staff and residents. Infection control education for staff has been provided by the infection control nurse. The registered nurse is required to complete infection control training. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Infection surveillance is an integral part of the infection control programme and is described in Ashlea Grove’s infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. A monthly infection summary for rest home and dementia residents is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections are entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the managers. No outbreak have been reported. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The service has documented systems in place to ensure the use of restraint is actively minimized. The facility was not utilising restraint on audit day and one rest home resident has an enabler in the form of environmental restraint. The resident requests to go in to the dementia unit during the day for socialisation and meals. The resident is able to ask staff to be let in and out and staff comply with the resident’s wishes. All necessary documentation has been completed in relation to the enabler. Staff interviews and staff records evidence guidance has been given on restraint minimisation, enabler usage and prevention and/or de-escalation techniques. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Staff education on restraint and enabler use has been provided. Restraint use audit has been conducted and restraint has been discussed as part of staff and management meetings. A registered nurse manager is the designated restraint coordinator. |

# Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.3.3  The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy. | PA Low | Full review of policies and procedures for the organisation has been undertaken by senior management from Elsdon Enterprises. New and/or reviewed policies are introduced to staff and discussed at staff meetings as evidenced in staff meeting minutes. The assessment and care planning policy does not include reference to conducting InterRAI assessments. | Policy around InterRAI assessment tool and processes has not been developed. | Provide evidence that policies and procedures have been developed to incorporate the use of the InterRAI assessment tool.  90 days |
| Criterion 1.2.4.3  The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. | PA Moderate | Incident and accident reports reviewed for June and July included falls, medication errors, fractures, skin tears, bruising, and behaviours. Six resident files reviewed included tracking of the incident, review of completed forms, entries in to progress notes of the event, review of risk assessments and care planning for the individual residents. Falls prevention and management, pressure risk reduction, behaviour management and skin care were well documented in the care plans reviewed. Pressure injury for one resident had been reported via the incident reporting system with associated wound documentation. The injury has now resolved. Wound care plans were in place for skin tears and short term care plans had been developed. | i) A review of six files, (with corresponding incident reports for two residents with falls, one resident with a fall and a skin tear, one resident with a fracture, one with behaviours, and one pressure area), did not evidence that a registered nurse had completed a clinical assessment of the resident in a timely manner. This included one resident with five falls sustained in June and four falls in July, and one resident who sustained nine falls in June. Incident reports evidence that an RN had reviewed the incident form but progress notes did not evidence a full clinical assessment of the resident had been conducted; ii) an incident report was not completed for one resident who developed a pressure area (June). | i) Ensure that a registered nurse conducts a timely clinical assessment of residents who experience an adverse event, and provide evidence that this is recorded on the resident’s records; ii) ensure that pressure injuries are reported via the incident reporting process.  30 days |
| Criterion 1.2.7.5  A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | Six staff files reviewed evidence that recruitment and staff selection processes have been followed. Reference checks are conducted prior to employment. Annual appraisals have been conducted for three of six staff files reviewed. Staff have received training since April 2015 in civil defence, chemical safety, infection control, dementia, elder abuse and neglect, restraint, cultural safety, challenging behaviours, manual handling and hoist use, continence and conducting neuro observations. There is an education plan in place for the remainder of 2015. On interview, the GP advised that further training around conducting clinical observations would be beneficial for caregivers, so that better information is able to be provided to GP’s when called out of hours. | a) Education around code of consumer rights and wound care remains outstanding, and training for caregivers on conducting clinical observations (temperature, pulse, blood pressure) has not been provided (noting these are scheduled this year); b) registered nurses have not completed InterRAI training for conducting InterRAI assessments on new residents (one RN is booked to commence). | a) Ensure that training is provided as per the current 2015 plan to meet the needs of all staff; b) ensure that both registered nurses complete InterRAI training.  90 days |
| Criterion 1.2.9.9  All records are legible and the name and designation of the service provider is identifiable. | PA Low | Resident files reviewed as part of incident report follow up and clinical files review, evidenced that caregivers were making entries on a daily basis. Registered nurse entries are less frequent (link #1.2.4.3). Entries in progress notes have a column for staff signatures but these are not always fully completed. | Progress notes entries are not fully signed by the staff member making the entry and the designation of the staff member is not always recorded. | Ensure that all entries in to resident records are legible and include the staff member’s full name and designation.  90 days |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | Medication charts are generated by the contracted pharmacy for GP’s to sign. Two medication rounds were observed. Controlled drugs are stored securely. The controlled drug register evidenced that weekly checks had been conducted, however these were not documented in red pen. Eye and ear drops had not been dated on opening. The service has in place policies and procedures for ensuring all medicine related recording and documentation is: a) legible, b) signed and dated, and c) meets acceptable good practice standards. Transcribing of medication orders on to administration signing forms has occurred in four of the 17 medication charts reviewed. | i) Controlled drug register weekly checks are not documented in red pen; ii) Two eye drops were not dated on opening; iii) Transcribing of medication orders on to administration signing forms has occurred in four of the 17 medication charts reviewed. | i) Provide evidence that weekly controlled drug register checks have clearly been conducted; ii) ensure that eye drops are dated on opening to ensure they are disposed of within the required time frames; iii) cease the practice of transcribing medication orders.  30 days |
| Criterion 1.3.12.3  Service providers responsible for medicine management are competent to perform the function for each stage they manage. | PA Low | An annual medication administration competency was completed for all staff administrating medications and medication training has been conducted, except for the registered nurses who have not completed training or competencies. | The two registered nurses have not completed medication training or competencies. | Registered nurses to complete annual medication training and competencies.  60 days |
| Criterion 1.3.4.2  The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning. | PA Low | Risk assessments including (but not limited to), falls, pressure area, continence, pain and nutrition were completed on admission and reviewed at least six monthly. Assessments such as behavioural assessments were completed for identified behavioural issues in files sampled. Assessments have not always been completed for all resident’s needs as evident in one of the rest home and two of the three dementia files reviewed. | One rest home file had no continence assessment completed and the pressure risk and falls assessments had not been reviewed for 12 months. Two dementia files had incomplete pressure and continence assessments. One dementia continence assessment had not been reviewed in past six months. | Ensure all required assessments are completed for all identified care issues.  90 days |
| Criterion 1.3.5.2  Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Moderate | An initial nursing assessment is completed within 24 hours of admission for three rest home residents and three dementia residents. Advised that the initial care plan is developed from the initial assessment and identifies the areas of concern or risk, however, initial care plans were not evident in the resident files reviewed. Short term care plans were utilised for acute health needs such as wandering, confusion at night, falls and elimination issues. | i) Initial care plans were not evident in the sample of resident files reviewed; ii) Short term care plans have not been utilised for all infections. | i) Ensure that all residents have an initial care plan in place to guide care staff; ii) Ensure that all short term care issues have either a short term care plan in place or changes are made to the long term care plan and include goals and interventions to guide staff in the safe and appropriate delivery of care and services.  90 days |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | Care plans document monitoring of weight to be monthly in all files sampled. Monthly weighs have not been completed for all residents. A request from the GP for weekly weighs for one resident had not occurred. Referral to dietitian occurs as required as confirmed by registered nurses interviewed. | i) Monthly weighs have not been documented for one dementia resident (June) and one rest home resident (April). A request by the GP in July 2015 that one resident in the dementia unit be weighed weekly has not occurred; ii) Wound management documentation does not include frequency required for dressing changes. | i) Ensure all interventions and monitoring is completed as directed by the medical practitioner and the resident care plan; ii) Review wound documentation to ensure all instructions and time frames are documented.  30 days |
| Criterion 1.4.1.1  Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements. | PA Low | Chemicals are labelled with manufacturer labels with the exception of two chemicals, one of which was decanted. This was discarded on the day of audit. There are designated areas for storage of cleaning/laundry chemicals and chemicals were stored. On day of audit cleaners cupboard was seen to be unlocked, this was corrected immediately and remained locked for the rest of the audit. | a) Chemicals are labelled with manufacturer labels with the exception of two chemicals, one of which was decanted (this was wine vinegar and was discarded on the day of audit). b) On day of audit cleaner’s cupboard was seen to be unlocked. | a) Ensure all chemicals are labelled with manufacturer labels and not decanted into another bottle. b) Ensure cleaner’s cupboard is secure when not in use.  60 days |
| Criterion 1.4.2.4  The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group. | PA Low | The interior of the building is maintained with a home-like décor and furnishings. The corridors are wide with handrails in place. Residents were observed to safely mobilise throughout the facility. The floor covering in all four communal rest home bathrooms has been replaced and the previous hazards have been eliminated. Carpet in rest home hallway has also been replaced. The communal bathroom flooring in the dementia unit requires attention. Advised by the service (quote sighted) that a contractor has quoted for the replacement of vinyl and work will be completed the next week. | One communal bathroom in the dementia unit has vinyl flooring lifting and cracked surfaces and paint work that is peeling. | Ensure that all hazards, such as uneven floor surfaces, are managed appropriately (minimise, isolate, eliminate) to provide a safe environment for residents and staff.  60 days |
| Criterion 3.1.3  The organisation has a clearly defined and documented infection control programme that is reviewed at least annually. | PA Low | Advised by management that the infection control programme is to be made universal for all four homes associated with the group. The policies and procedures have been reviewed in June 2015. | The infection control programme has not been reviewed in the past 12 months. | Ensure that the infection control programme is reviewed annually.  90 days |
| Criterion 3.4.1  Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice. | PA Low | The registered nurse has been in the position for ten weeks. Education for staff has been provided informally at handover times, when there is an emergent issue and at a formal education session. The registered nurse has not completed recent formal training around infection prevention and control. | The registered nurse (infection control coordinator) has not completed formal infection control training. | Provide evidence that the infection control coordinator has completed IC training.  90 days |

# Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

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